STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
OFFICE OF CONSUMER AFFAIRS
CORDELL HULL BUILDING, THIRD FLOOR
425 5TH AVENUE NORTH
NASHVILLE, TENNESSEE 37243

Tennessee Certified Peer Specialist Certification Renewal Application

Please Print

Renewal Application PART I – Applicant Contact Information and Verification of Status

Full Name: _____

Certification Number: _____ Certification Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone Number: (_____) _____ - _____

Email: _____

Circle:

- I am currently employed by an agency licensed by the TDMHDD.** Yes ☐ No ☐
- I am under the general supervision of a mental health professional.** Yes ☐ No ☐
- I perform duties specified in the TCPS Scope of Activities.** Yes ☐ No ☐
- I have successfully completed twenty (20) hours of recognized on-going education. Yes ☐ No ☐
- I certify that I have not committed any violations to the TCPS Code of Ethics; in addition I have no reports of violation to the TCPS Code of Ethics. Yes ☐ No ☐

If you circled "No" on any of the statements above, please explain: _____

_____

_____

** Employment is <u>not</u> required for continued certification.

Renewal Application PART II – Verification of On-going Education

Twenty (20) hours of on-going education are required annually to maintain active certification and must be earned within the annual certification period. Please refer to Section VI of the TCPS Handbook for On-going Education requirements.

List the title and date of the training, the sponsoring organization, and the number of hours for each training attended. Submit this application with a copy of the Certificate of Attendance or Completion for each training listed.

1) _____ _____
Title of the Training Sponsor

_____ _____
Number of Training Hours Training Date

2) _____ _____
Title of the Training Sponsor

_____ _____
Number of Training Hours Training Date

3) _____ _____
Title of the Training Sponsor

_____ _____
Number of Training Hours Training Date

4) _____ _____
Title of the Training Sponsor

_____ _____
Number of Training Hours Training Date

_____
Total Hours of Training

My signature below affirms that all of the information attached to and contained in this certification renewal application is true and correct to the best of my knowledge. I understand that knowingly providing false information shall be grounds for termination of certification.

_____ _____
Signature of Applicant Date

Note: The Certification Renewal Application and all required documentation must be submitted at least forty-five (45) calendar days prior to the end of the current certification period.

Currently working as a TCPS Yes ☐ No ☐
If no, omit part III of the application.

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Renewal Application PART III – Employment Summary – Completed by the supervising mental health professional. May be omitted if not currently working as a TCPS.

A Certified Peer Specialist must be under the general supervision of a mental health professional licensed by the State. Provide the following information regarding the agency staff that provides direct supervision:

Supervisors' Name: _____

Credentials: _____ Position: _____

Agency: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (_____) _____ - _____ ext. _____

Email: _____

Applicant's Name: _____

Applicant's job title within the agency: _____

Full-time / part-time (circle one) Number of hours worked per week: _____

Certification number: _____ Certification Date: _____

Circle:

- The applicant is employed by an agency licensed by TDMHDD. Yes ☐ No ☐
- The applicant is under my general supervision. Yes ☐ No ☐
- The applicant performs duties specified in the TCPS Scope of Activities. Yes ☐ No ☐
- The applicant has successfully completed twenty (20) hours of recognized on-going education. Yes ☐ No ☐
- I certify that I have not committed any violations to the TCPS Code of Ethics; in addition I have had no reports of violation to the TCPS Code of Ethics. Yes ☐ No ☐

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If you circled "No" to the last statement above, please explain: _____

_____

_____

_____

_____

I verify that all of the information contained in this document is true and correct to the best of my knowledge, and that the above named applicant is employed by an agency that is licensed by TDMHDD and authorized to participate in the Medicaid program.

Signature of Supervising Mental Health Professional Date

Do Not Write Below This Line

Internal TDMHDD – OCA Use Only

Date received:

Date reviewed: Approved Not-approved

Date letter of findings mailed to applicant:

Date information recorded in data-base:

Notes:

Processed by: